PUBLIC HEARING

RE

TEN-YEAR COPA REVIEW

FOR

BENEFIS HEALTHCARE

Civic Center
Great Falls, Montana
June 27, 2006
5:00 - 8:00 p.m.

HEARINGS EXAMINER:

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BE IT REMEMBERED, that on June 27, 2006, at the Civic Center, Great Falls, Montana, before Katherine J. Orr, Hearings Examiner, the following public hearing was held:

(Proceedings commenced at 5:00 p.m.)

(Call to order.)

MS. ORR: Good afternoon. My name is Katherine Orr, and it looks like we have a very large turnout today. That's encouraging for the community. I'm here from the attorney general's office.

I am -- I've been asked to be here on behalf of Mike McGrath, the attorney general, and we set this hearing today in the Missouri Room at 5:00 to take public comment on the ten-year review of the Certificate of Public Advantage that's been issued to Benefis Healthcare. It's amazing that it's already been ten years, but -- but it has, and under the Certificate of Public Advantage, the department is actually obligated to review the issuance of that certificate, and that's why we're here today.

I wanted to read to you the location of where you can submit written comments if you would like. We're taking oral comments today, but we're also asking for written comments for any of you who would like to provide them to us.

And I don't know if -- if you all have pencils,

but it's to the Attorney General, Mike McGrath, P.O. Box 204 -- 201401, Helena, Montana 59620; or email at contactdoj@mt.gov; and simplest of all, you can look on our web site, and that will give you the address of where to submit written comments, and that's www.doj@mt.gov. We're taking written comments until July 10th.

For ease of -- of this hearing, what I would like to do is divide it into the following format: First we will hear from those who are contending that the COPA should be repealed or dissolved; then we will hear from those contending that COPA should be maintained, modified or amended; then we will hear from those who wish to make any comment on the COPA. The last half-hour will be allowed for follow-up comments.

There's a sign-up sheet in the back of the room, and please --

AUDIENCE MEMBER: Excuse me, could you talk into the microphone, please? We can hardly hear you.

MS. ORR: Okay, maybe this --

AUDIENCE MEMBER: Thank you.

MS. ORR: I'm not used to having it right near my -- my face.

There's a sign-up sheet in the back of the room; please sign in. And when you come to the podium to speak, it would very much help our court reporter if you could

clearly state your name and the company you're representing, if any, and also it would be very helpful to know if, in addition to submitting oral comments, you will also be submitting written comments, so please state that as well.

I think it would be beneficial for all of us if your cell phones were turned off. And mine isn't; I'll turn it off right away. And I think we should take a break about every hour, and that will be a short break.

There will be instances where our court reporter is going to need to change her tape or her paper, and I will alert the speaker to that. Also, if you have prepared written comments, it would be very useful if you could provide a copy of those to me with your name on it and with an identifying address or telephone number.

Are there any questions before we begin? Well, let us go ahead and begin, and we'll start with taking comments for those who would like to make -- or talk about a position regarding repeal or dissolution of the COPA.

Thank you.

MS. MOE: You've got me worried about this microphone, Ms. Orr.

MS. ORR: It's -- it's turned way up and it's turned on. If you want to move it near you, that would probably be the best.

MS. MOE: I don't know that I can. Can you hear me?

AUDIENCE MEMBER: No.

MS. ORR: Talk absolutely right into the mic.

MS. MOE: Okay.

AUDIENCE MEMBER: Angle it up a little, Mary.

MS. MOE: Is it on?

AUDIENCE MEMBER: Yes.

MS. ORR: Yes.

MS. MOE: Is that better, then?

AUDIENCE MEMBER: No.

MS. ORR: Just try to -- try to speak right into the mic.

MS. MOE: Good evening, Hearing Officer Orr, and welcome to Great Falls.

MS. ORR: Thank you.

MS. MOE: For the record, my name is Mary Sheehy Moe, and I address you as one of the 15 members of the board governing Benefis Healthcare. We're here to ask you to sunset the COPA that has regulated Benefis Healthcare for the past decade. Briefly, here are the reasons:

In 1996, given the concerns about lack of competition after the merger and the uncertain future of this new community hospital, the COPA was an appropriate

protection for this community. In 2006, though, those concerns no longer exist. In fact, in 2006, and for as far ahead as economist dare to project, the viability of what is now a top-notch community hospital is threatened only if Benefis cannot protect access to healthcare regardless of ability to pay in a healthcare environment that is increasingly competitive and no longer place bound.

In 1996 the COPA laid the ground rules for a fledgling hospital. In the decade since, Benefis has far exceeded the COPA requirements. Thanks to an exceptionally capable and caring medical staff and management team, Benefis has become not just a good hospital, but a great one.

You're concerned about cost? We all are. Benefis Healthcare took costs that are 10 percent above the regional average in 1996 and brought them down to a 2006 level that is 18 percent lower than the regional average.

Benefis met the COPA expectation for cost. But if all Benefis cared about was COPA compliance, we'd be right in the middle of pack, not 18 percent lower. We keep our costs low because we know cost matters to the attorney general, certainly, but more importantly, to our patients.

You're concerned about access? We all are. Today Benefis Healthcare provides access to all the services that this community had in 1996, and more. Did the COPA help? It set the expectation. But if all we cared about were complying with COPA, we'd have done only what we had to do to maintain the 1996 level of service.

Look around this community and region. Benefis has added countless healthcare services at its own venue, and we've allied with such partners as Northern Montana Healthcare Alliance and City-County Health and others, so that they can expand access as well.

You're concerned about quality? We all are. Benefis has not only met the COPA standards for quality, but has constantly sought other external reviewers to evaluate services. They've given us award after award for quality. I won't list them here, they're in the record, but sometimes this community doesn't give itself enough credit for its accomplishments.

And what this community hospital has accomplished in ten short years is truly remarkable. That took a combined effort of clinic docs and independent docs, of former Deaconess employees and former Ben -- or Columbus employees, of board, and management, and staff.

As a board, we are grateful to all in this room who played a part in making this triumph happen. In the

last ten years, Benefis Healthcare has transformed two hospitals with fragmented services and duplicated programs into the strong community hospital this region wants and needs.

But COPA helped set the tone. But the real reason is that this board of directors, this senior management team and this group of 2400 amazing employees have internalized the values of affordability, quality and access to a degree that outstrips regulations. Those values are part of the culture at Benefis Healthcare now, and they always will be, not because the state requires them, but because we at Benefis are committed to them.

In the decade to come, another danger looms for this community and its hospital: The inevitability of competition. In 1996 the state thought of competition as another full-service hospital in the same community, the competition, in other words, that we lost in the merger. No one could imagine then how specialized, boutiqued, technologically delivered, outsourced, joint-ventured and cherry-picked health services could become in a mere ten years.

In the new flat world of 2006 and beyond, every community hospital faces competition that can be local, regional, global, and various combinations of the three. We can't stop it, and neither can you. Benefis must be

able to compete in this environment as other community hospitals in Montana do.

What's at stake if we can't? Benefis is the brightest star in our local economy, generating one out of every five dollars circulated in this community. Benefis provides 2400 high-wage jobs here, more than any other nongovernment employer. Benefis is located in, committed to, actively involved in and returning profits to this community and this region.

But that's not what's really at stake. What's at stake is the mission that drives Benefis Healthcare. Hearings Officer Orr, every decision we make as a board, every directive our senior management takes and every service our employees deliver springs from a deep commitment to one thing, making sure that every human being, regardless of ability to pay, has access to high-quality healthcare as close to home as possible.

There are lots of interconnected pieces to that belief. If competition nicks away at some of them, the others becomes harder and harder to maintain. After enough nicks and slashes, maintaining anything of quality becomes impossible.

The COPA was instituted to compensate for the lack of competition in Great Falls healthcare. It served its purpose for the healthcare environment of the 1990s,

but the COPA cannot protect this community in the competitive environment of the 21st Century, much of which none of us could even imagine then.

Further state regulation will only keep our community hospital from protecting itself and all of us in northcentral Montana. Your office set us on the right path, but this twig has grown. Please sunset the COPA so that we can protect what really matters about healthcare to the people in this room and all the people beyond it, access to the very best care as close to home as possible, regardless of ability to pay.

Thank you.

MS. ORR: Excuse me, we're going to try to turn up the microphone a little bit.

DR. MUNGAS: Can you hear that?

AUDIENCE MEMBER: No.

DR. MUNGAS: How's this?

AUDIENCE MEMBER: Better.

DR. MUNGAS: Better?

AUDIENCE MEMBER: Better.

DR. MUNGAS: Ms. Orr, thank you for the opportunity to make a statement.

MS. ORR: Thank you.

DR. MUNGAS: I will submit some written information following the meeting.

My name --

MS. ORR: If you could state --

DR. MUNGAS: -- sorry -- is James Mungas. I'm a general and vascular surgeon, and as of August of this year, I will have practiced in Great Falls for 30 years. I come here today to support and endorse Benefis hospital's request that it be given relief from the restrictions of the COPA.

Prior to the merger of Montana Deaconess and Columbus Hospital into Benefis Healthcare, both Deaconess and Columbus hospitals were strongly supported by different factions of the medical community. This support of the hospitals by local physicians allowed each hospital to become very effective in providing needed healthcare to all of northcentral Montana.

At the time of the merger of Deaconess and Columbus hospitals into Benefis Healthcare, the COPA was a necessary and appropriate requirement. However, ten years have passed, and many things have changed in Great Falls.

Benefis hospital is still our community and regional hospital. Benefis provides necessary care to all patients, turning nobody away 24 hours per day, 7 days per week, 52 weeks per year, including holidays.

Many of the smaller hospitals in our region rely heavily upon Benefis regularly transferring patients for

complex treatment and care that they are not able to provide in their own smaller hospitals.

Benefis hospital is governed by a board of trustees represented by community leaders whose mission and responsibility it is to see that Benefis continues to have the resources, personnel and facilities necessary to provide care to all patients at all times, regardless of their ability to pay.

As things have evolved over the last ten years, Benefis is certainly not a monopoly, and its ability to provide necessary services is becoming increasingly difficult because of competition from medical centers in other states, from other cities within Montana, particularly Billings, Missoula and Kalispell, and also from within the city of Great Falls itself, most specifically, the Great Falls Clinic.

The Great Falls Clinic, since the hospital merger occurred and the COPA was instituted, has taken a very competitive stance regarding the hospital. Specifically, it has started providing many revenue-generating service previously performed at the hospital, such as nuclear medicine, outpatient CT and MRI, PT, OT, outpatient surgery, radiation oncology, and cancer care. All of these are revenue-generating services.

Recently the clinic has partnered with an

out-of-state firm, Essentia, to purchase the operating interest in Central Montana Hospital in Great Falls. Their intent is to compete directly with Benefis. Because of the clinic's partnership with Blue Cross Blue Shield through Montana Care, they are able to direct paying patients away from Benefis and into their own institution.

In order for Benefis to provide emergency care to all patients 24 hours per day, they must be able to provide nursing and technical staff around the clock, and yet this other competitor aggressively and regularly recruits personnel away from Benefis hospital, stating in their ads that their own jobs are more attractive because they are, for the most part, daytime jobs with little or no night or weekend call.

The Great Falls Clinic operates, except for some limited Saturday morning clinics, only from Monday through Friday and does not provide emergency services within their own facility after hours, at night, on weekends or on holidays.

The sickest patients with the most serious medical problems and the worst injuries continue to come to Benefis, and yet, because of outside competition, Benefis' ability to respond to such patients' needs is being increasingly threatened by flow of revenue, resources and personnel away from the hospital.

Many services provided by Benefis do not generate enough revenue to cover the overhead. Examples are the emergency and trauma services, Mercy Flight, dialysis, psychiatric services, and chemical dependency. In the face of dwindling funds from other sources, these services face the real danger of being reduced or eliminated.

Benefis fulfills its responsibility to our community and region and should not be hampered in its ability to provide services that others are not willing to provide. Benefis is a community resource and should be supported at local, regional, state and legislative levels. Benefis should be allowed to compete with outside forces on a level playing field.

It is not good that the one institution in Great Falls which now provides continuous service and is a true community -- a true community resource should be the only one bound by the COPA restrictions, particularly in the face of ongoing competition from outside.

I believe that Benefis should be released from the requirements of the COPA in order to compete and remain a strong community asset capable of responding to the many needs and challenges of patients requiring healthcare in our region.

Thank you.

MS. ORR: Thank you.

MR. JACOBSON: Good evening. My name is Jerry Jacobson, I'm from Glasgow, Montana, and I thank everybody for allowing me to come tonight and speak on behalf and for Benefis hospital.

I was a patient here. I had the experience of being here for 459 days. And that was after spending 7 days at Glasgow. We chose this location because it was centrally located for our family and because of the small hospitals that were just talked about in eastern Montana did not have the facilities to handle the type of medical help that I needed.

I don't want to go into it too far, but within about the third day of being here in Benefis, why, I was completely paralyzed, including my eyes and eye lids. I was on a ventilator, stomach tubes, and all the rest of the tubes that go along with it. And I spent six weeks in ICU, I spent about the next nine months in PCU, nine-and-a-half months on the ventilator, and then the rest of the time I was very fortunate to be in rehab.

I had just about every type of care that could be had at Benefis. I believe there were 30 -- I was attend by at least 33 doctor specialists, I don't know how many hundreds of nurse, nurses aids, therapists and other technicians.

My experience, I would rate this as excellent. We had nothing but praise for everything that happened for me. We developed many close friends, some of whom are here tonight. Good evening. Every time we come back or go through, we try to go to the hospital and say hello to as many of these friends as we can.

I recommend highly to the friends and everybody I meet in Glasgow, Montana that if they have the need of a hospital, that Benefis is a real nice place to come. And I know that some of those folks have come.

I visited other hospitals in -- after my illness in trying to help some of these folks through the problems and some of the similar problems that I had. And my prognosis was, basically, if I lived, and they didn't expect me to live very -- several times they called the family together, that I would always be respirator dependent and quadriplegic the rest of my life. And as you can see, I wouldn't win any races, but I'm walking, and I'm talking, and I'm feeding myself, and everything else that goes along with it.

One of the things that we found is that the friends that we developed, it became just like a family. Some of the male nurses would bring their wives and children in, some of the lady nurses would bring their husbands and children in, and this helped an awful lot.

And, of course, we had lots of visits from the family because this was centrally located.

I would like to recommend Benefis to anybody else that has the care that I needed. Thank you very much for being here.

MS. LONEY: I'll go through the microphone routine. Can you hear me okay?

AUDIENCE MEMBER: No.

MS. LONEY: No?

MS. ORR: You have to speak right --

MS. LONEY: Is that better?

Okay. My name's Cherry Loney, and I appreciate the opportunity to speak here tonight.

Jerry, you have an amazing story. God bless you.

I work at the City-County Health Department. I've been employed at the health department for 32 years. I'm the executive director there, and I've been in that position for 18 years.

I speak in favor of sunsetting the Certificate of Public Advantage that was put into place when our two hospitals merged. And I want to talk about that from the perspective of the lower income people in our community, and I will tell you why as I continue here.

One of the basic responsibilities of public

health is to assure that all people, regardless of income or insurance coverage, have access to healthcare. To that end, we offer primary healthcare and limited dental services through a community health center within the health department. This program operates side by side with our traditional public health services.

Our patients are largely residents who are lower income, have no health insurance coverage, or for whom coverage is limited. This means that they have limited services or they have a very high deductible. Commonly that's referred to as being underinsured.

We are one of a network of about 3500 such health centers nationwide that exist to provide cost effective, quality healthcare to the medically underserved people in our nation. Uninsured patients pay for their care on a sliding fee discount scale. To help cover the cost of care, clinics also receive partial federal funding, and they bill all insurances. In our case, our federal grant covers less than 50 percent of our costs.

I want to offer a little background on our clinic. As I said, I've been around for a very long time, and so I remember when we had a Deaconess and a Columbus, I remember the merger, and that happened about the time that our clinic was created.

Several years ago medical indigence was a

problem of increasing significance in our community. There was a staggering 37 percent, or roughly 28,500 county residents, who were below 200 percent of federal poverty. About 14,000 of these people had no insurance, either public or private. And when I say public insurance, I mean Medicare or Medicaid.

State assistance for medical care for the poor has decreased considerably, leaving most of our adults who are poor with no resource to pay for healthcare or for prescription drugs.

To compound the problem, there were a number of special populations within the community with no resources for healthcare. This included the landless Native Americans, college students with no campus health services, residents at the local pre-release center -- and the State of Montana does take the position that they come here voluntarily to the pre-release center and, therefore, they do not provide healthcare for them unless they go back to Montana State Penitentiary -- and we also have a fairly large homeless population.

The mortality and disease morbidity was disproportionately high in this population, as you might imagine. To help address the problem, we collaborated with Great Falls health and human service providers to secure a federal grant to operate a community health

center, so that we could provide an avenue of primary healthcare for this medically underserved population.

We were successful in our grant application. The clinic started in 1994 as a division of the City-County Health Department. Today the clinic provides healthcare to about 5500 patients annually. The vast majority are low income and uninsured. Many of them are in fairly poor health.

They have a lot of pathology because they have gone without healthcare, without preventative healthcare or basic healthcare, for a very long time, and they also have a number of socioeconomic issues that bear on their ability to access and use healthcare, for example, housing, transportation, a good many of them of substance users, and so on.

We work with all healthcare providers in the community, including the hospital and the various physician groups, Indian Family Health Clinic, and Malmstrom Air Force Base. We value positive relationships with all the healthcare providers in our community, for without their ongoing support and collaboration, we simply could not succeed.

Benefis Healthcare plays a major role in assuring the poor in our community have access to healthcare. For example, they waive the cost of various

diagnostics done at the hospital for our patients. Our clinicians refer all patients for x-rays to the hospital, and the hospital charges us only for the cost of the film.

Patients in our clinic receive inpatient care regardless of their ability to pay, and most of them can't. Our clinic is limited in capacity. We see about 5500 active patients annually, but there are an estimated 15,000 people in the community today who don't have health insurance.

Many of them access care through the Benefis emergency room, so the hospital is effectively providing primary healthcare as well, and we all know that's a very expensive venue to provide primary healthcare.

We are out of room at our facility. We've outgrown it, but we can't extend services to more people without additional space. The hospital has recently put up funds to be matched by other community entities to help with the cost of building expansion for us. This type of support is absolutely essential. Even with that, we are falling short of even coming close to meeting need.

Sadly, the economics are no different here than they were ten years ago, when our clinic was created. The need is greater than ever, and the number of uninsured is greater than ever. We're being called to serve more and more people.

A financially strong hospital is critical to helping assure we can sustain these services, as well as continue to grow and better respond to the relentless need out there.

I served as a member of the Regional Community Health Council that was created by the attorney general at the time of the merger. Council members knew from the beginning that our role was temporary, and the group has long since disbanded. We met and met until we could find nothing more to meet about, and so our group disbanded.

The COPA was a good thing, and it was needed at the time of the merger, when there was a different healthcare environment and a need for a different type of regulation than there is needed today. But it, too, has served its purpose, and that method of regulation needs to be lifted in lieu of the regulatory board of directors and the community, who will serve as the regulatory body for the hospital.

Thank you.

MS. ORR: Thank you.

MR. AHRENS: Name is Jim Ahrens, A-h-r-e-n-s.

Good evening. I'm Jim Ahrens. I'm the president of the Montana Hospital Association, and we represent hospitals, nursing homes, home health, hospice, all kinds of services across the state, so I can tell you

we can see the state from a very broad view, and there's a lot going on in the state of Montana and a lot of competition going on. So I appreciate the opportunity to testify this evening.

We were involved, that is MHA was involved, in the development and enactment of this legislation, the legislation that established the Certificate of Public Advantage. I lobbied it and our staff lobbied it, so we were present at the creation and can tell you all about that if anybody's ever interested.

So it was a -- it was an interesting issue. It was the right thing to do at the time. It was brought about because of the legitimate concerns about the fallout from the merger of Columbus and Montana Deaconess hospitals, and many of you can remember those days.

In particular, there were very serious concerns about whether the lack of competition between hospitals in Great Falls would result in reduced access to medical treatment, higher cost of hospital services and/or erosion of quality of services. And so we enacted the COPA that provided a vehicle for ensuring that the merged hospital would continue to serve the community's healthcare needs and that the cost savings promised with the merger would be realized. And this has happened.

But it's ten years later, and from where we sit,

we don't think the COPA is any longer necessary. In today's healthcare environment, the concern of lack of competition for healthcare providers in Great Falls no is longer an issue. It's no longer an issue, really, in most areas of the state.

Like I say, delivery -- first, the delivery of healthcare services has changed dramatically since 1996. Everything has changed. There was hardly any laparoscopic surgery at the time. There was just all kinds of different things going on in the world.

New technology, new treatment techniques have resulted in a massive shift in where medical treatment can be delivered. In addition, the number of providers in Great Falls has steadily increased. And as a result, the number of services that can be and are provided at locations other than a hospital continues to grow, and they will continue to grow in the foreseeable future.

Thus, for many services today there is intense competition among Benefis -- among Benefis or between Benefis and local physicians' offices, the Great Falls Clinic, and other physicians groups. The development -- the development of the Central Montana Surgical Hospital will accelerate the trend.

Second, as a tertiary care center, Benefis competes with major hospitals in other parts of the state

and the region. Ten years ago, Kalispell didn't offer open-heart services. They actively compete in the market today. Missoula didn't actively recruit, at that time, cases from Great Falls, Helena and Butte. There's a lot of competition going on today. Since I'm from Helena, I know that to be a fact, and it's a fact in Great Falls. So this is all taking place.

This competition in healthcare ensures the cost of care is appropriate and the quality remains high, and that access to services is not reduced. Unlike ten years ago, today's healthcare environment in Great Falls is already highly competitive, and as a result, fears about the impact of the merger are no longer valid. For this reason, we endorse Benefis' petition to end the COPA.

Thank you for the opportunity to testify.

MS. ORR: Thank you, Mr. Ahrens.

MR. CUMMINGS: I'm Jim Cummings, and I'm the board chair of the Benefis board, and I'm a part of the 15 member volunteer local community board who sets strategy and helps with the management of the hospital.

I would like to -- because there are only a few of the board members speaking tonight, I'd like to have all the past members of the Benefis board and the current members of the Benefis board that are here in attendance to please stand. Thank you.

And in addition to that, there are some members from the Benefis Healthcare Foundation board, and I'd like to have them please to be stand -- please stand. Thank you.

We're here today to discuss with the attorney general's staff and with our community why there is no real reason to continue with the COPA or Certificate of Public Advantage. During the 1990s, when mergers -- hospital mergers were the vogue, Certificate of Public Advantages totaled 15. There are only 3 COPAs left in existence in the United States, and that includes Benefis. The other COPAs have been sunsetted because the need to assist healthcare as ceased.

The original Benefis COPA had a ten year evaluation review provision to confirm if it should be maintained, discontinued or modified. The attorney general and the legislature knew there probably would not be a need to continue the COPA when they enacted the legislation. The associated expense and the control of offered services, the revenue cap, are a time intensive response effort, and they're costly. None of this effort or cost lead to a greater hospital efficiency, economy or improved quality of care.

For ten years the COPA has shown that Benefis can and has controlled costs. These service costs have

increased an average of 3.1 percent per year. This cost control is considerably lower for peer hospitals in Montana and in the rest of the United States. The learned skill because of COPA and management and operation will continue at Benefis and be an aid to our community healthcare.

Not only does Benefis have considerable competition in Great Falls, but there's significant out-migration of services to other Montana hospitals, Kalispell, Missoula and Billings. Through September of 2005, this out-migration represented 25 percent of the total charges in Cascade County and the northcentral Montana region, and it ranged from 6 percent for women and children's health to 47 percent for cardiovascular services.

Please take these comments into account and consider sunsetting the COPA. Thank you.

MS. ORR: Thank you.

DR. REICHERT: Assistant of the attorney general, members of the audience, my name is Dr. Cheryl Reichert. I have written testimony that I will be adding.

As a physician who practiced medicine at Benefis and its predecessor, the Columbus Hospital, and as an individual who served as the medical director of a

hospital based pathology practice, I believe the hospital should be conditionally released from the financial restrictions of COPA oversight. I only speak to the financial aspect.

An absolute condition of relief from state regulatory oversight, I believe, that is crucial is that patients themselves be given computerized access to cost data for various hospital services and procedures. We're talking about competition. Competition isn't going to work if the patients don't know how much procedures cost.

The reason for my suggestion is as follows:

The COPA is subject to statistical manipulation. For example, if a hospital increases the price in one area by ten percent and reduces it in another area by ten percent, there's been no effective price increase, but if the ten percent increase is in a commonly done procedure and the decrease is in something that hardly is done, you can see the net effect.

Secondly, there is no other type of service than healthcare offered -- other than healthcare that's offered with such a lack of financial accountability. Although patients are asked to give informed consent before a procedure or a hospital admission, cost is not part of the information that's provided. To the contrary, the hospital billing codes for a non-Medicare/non-Medicaid

patient, which are different than the CPT codes, make it very difficult for ordinary patients to try and compare billing costs.

The facts -- the fact that charges for a given procedure may differ from one patient to the next doesn't preclude the hospital from offering a price range for common procedures or services. Medicare figured this out 20 years ago with the DRG plan for reimbursement based on averages. Medicaid and CHAMPUS soon followed suit. Many large private insurance companies and HMOs consequently jumped on board and negotiated their own deals.

So now the hapless underinsured or uninsured are actually charged the very highest fee, for which the sky is the limit. I'm not talking about the indigent patients who have no assets, I'm talking about the working families who lose their homes in the process.

Now, with this particular approach, everyone is technically charged the same amount for the same service, but what the hospital actually receives in payment is a very different matter. So if it's $1,000 that's the actual charge, Medicare may reimburse a few hundred dollars, private-pay insurance a little more, but the poor uninsured or underinsured patient gets the full hit.

This isn't unique to Benefis. This scenario's being replicated by hospitals across the country, and the

solution is relatively simple. And we who are served by Benefis have the unique opportunity to lead the country in trimming hospital costs through a truly competitive marketplace.

This hasn't happened before because there hasn't been a funding source and there hasn't been access to the Internet as an efficient means of displaying and distributing the data. Reimbursement costs for Medicare and Medicaid patients should be disclosed at the same time, and these charts should include quality assessments.

Our federal government has recently recognized how important it is to post the costs for common hospital procedures on line, and I've attached that form for you to take a look at. Even foreign governments are now advertising total costs of procedures, such as hip replacements in India. Certainly we can figure this out.

I had a friend who recently had hip replacement surgery. For 2 days in the hospital, her hospital bill here was $29,000. That does not include doctors' charges. I have another friend who went to India for the procedure: $8,000. That included round-trip airfare, a private-duty nurse, and a one-week vacation at a resort where she recuperated.

So it's clear that competition is here, it's going to be on a global market, but what good is it if

people don't know how much it's going to cost? This type of competitive approach will have a much more positive impact on healthcare affordability than the current COPA. And because Benefis has lower prices than hospitals in Billings or Missoula, we should be proud of that fact, and we can recruit more patients to our community.

Let's take the money currently being used to fund the COPA and use these dollars to distribute the information that will arm patients with the ability to make rational decisions about their healthcare and their pocketbooks.

Thank you.

MS. ORR: Thank you.

DR. GELERTNER: What we have here, Cheryl, is dejavu all over again.

My name is George Gelertner. Can you hear me?

AUDIENCE MEMBER: Yes.

MR. GELERTNER: My name is George Gelertner. I'm a retired physician; I've practiced here for 50 years. I was also chairman of the Deaconess board of directors at the time of the -- of the great commotion.

And I -- I thought it might be of some interest, because there are many young people who may not know what the circumstances were and what the environment was that triggered all of this, and so I'm going to try to be

mercifully brief and -- and go over it.

It was a time when hospitals were in great crisis. There was loss of income, reimbursements were down, beds were not being filled, and costs were going up. Hospitals were closing, hospitals were downsizing, and they were joining larger groups, many for profit.

This created an awareness, certainly on our parts, that in the meantime our two competitive hospitals were merrily going about their business on a downhill slide into bankruptcy. And it caused us enough concern to think that we had to do something to -- to stop it.

And this led to discussions, and more discussions, and more discussions. And we had finally enough meeting of the minds to realize that probably one of the hospitals couldn't survive, and we would be left with one, and this then finally led to the merger.

Now, with the merger there also became other concerns, and one was oversight. We had at the time in the federal government a very aggressive, in fact hostile, antitrust feeling, and consequently, we then turned looking for state control. The legislature accommodated this by allowing the COPA, and the COPA was well received. We certainly wanted to have state control rather than federal.

This went on, and more -- everything that we

did, something else became apparent. And the other thing that became apparent was that a stand-alone hospital was vulnerable for takeover either by a for-profit or a hostile takeover. And then this led to the partnership with Providence Services, which represented the Sisters of Providence, who had served the west very well for over a hundred years. And that was kind of a -- a happy marriage.

And we also -- because I've been here 50 years, I forget sometimes what "we also," but we -- we had a lot of alsoes. But this obviously served the community well.

The -- what has followed stands on its own record, obviously. The hospital has been magnificent, and we certainly have appreciated the input from the COPA, and all is well, except now the conditions, the environment are entirely different, as has been spelled out.

We now have competition all around us, as noted and will be discussed in greater detail later, and I'm here to respectfully add my name to request termination of the COPA, and I would add thank you to the attorney general's office for the service you rendered.

Thank you very much.

MS. ORR: Thank you.

DR. MELASHENKO: Good afternoon. Can you hear me or have I --

AUDIENCE MEMBER: A little closer. I turned it --

DR. MELASHENKO: How about there? How about here? Okay. If you can't hear me, just wave in the back. I'll go to shouting.

Good afternoon. Name is Robert Melashenko. I'm a physician, an anesthesiologist by trade. I'm a member and vice president of the Anesthesia Associates of Great Falls. We provide the anesthesia services for Benefis Healthcare.

I am here -- okay, I see -- I'll try and get louder here.

I am here to support the removal of the regulations on Benefis Healthcare, and the reason that I am here for this is a rather simple one. As an anesthesiologist, I have the rather unique position that I share with my surgical colleagues in being able to or being requested to go to the various parts of the hospital, usually those involved with very intensive, technical medical services; and by those I mean the surgical intensive care unit, the cardiac intensive care unit, the emergency room, just to name a few. And, of course, we make our home in the operating room, which is a very fun place to work, very technical, and oftentimes very critical.

And being able to go to those different areas of the hospital, I am exposed to the unalterable fact that there is large numbers of people here in Great Falls, not to mention the ones that are flown in from Mercy Flights with Mercy Flights from elsewhere, that utilize these services 24 hours a day, 7 days a week, 365 days a year. And we take all comers. There are no restrictions.

Unfortunately, these areas, due to the technical and the type of services they provide, tend to serve people who are at a loss or do not have full capabilities of supplying their financial resources to pay for their medical care. And some of this care can go on, as you heard earlier, for an extended period of time.

Central Montana hospital, as it is now configurated, does not have an emergency room, does not have a surgical intensive care unit, does not have a cardiac intensive care unit. It does have an operating room, but for those of you who are knowledgeable about how hospitals work, most of the emergency critical surgical patients are admitted through the emergency room after hours, on weekends and holidays.

So without an emergency room, Central Montana will have a greatly decreased window of exposure to the type of patients which can be the most critical and the most costly to serve.

Well, given those facts, I need to take it a step further. A few years ago, the Great Falls Clinic opened an outpatient surgical care center, and they hired their own anesthesia care providers. I was not here at the time, but my colleagues have informed me that they noted a decrease, a significant decrease, in the amount of outpatient surgeries for which they gave anesthesia. And, unfortunately, they also noted an even greater decrease in the amount of patients coming for surgery on an outpatient basis who had some type of financial means to pay for their medical care.

Our -- my -- our worry is this: If that same scenario is now played out in the inpatient arena that had been -- that has been played out in the outpatient arena, the consequences financially to Benefis Healthcare will be severe.

Therefore, it's simple from an anesthesiologist's point of view. We make our living in this hospital and have a very vested interest that it keep open and be able to provide the type of services that are required by this community. We are asking that the COPA regulations be removed from Benefis Healthcare.

MS. ORR: Thank you.

MR. NELSON: My name is Dean Nelson. I'm a former board member of Benefis Healthcare. I was on the

board for about eight years, and while I was not a part of either one of the boards that -- that were involved in the merger of the hospitals, I came on shortly after that.

When -- when the two boards began to discuss how they were going to merge the two hospitals together, they -- they were very courageous, actually. The community had tremendous concerns about how -- what the outcome would be if we had one hospital in our community instead of two. And the -- those -- those boards had the courage to move forward with that and find ways where they could overcome the concerns that the community had.

The COPA was born to overcome those concerns, not just the financial pricing concerns, which, of course, were predominant in the discussion, but also services that would be provided to the community and would they be -- we, the public, be assured that those services would continue. And the COPA addressed all of those things, and rather successfully did.

The boards went forward with that merger, really, based on the confidence that two things would happen. And I'm certain that my healthcare professional friends can create this in much more detail, but simply stated, they were -- they were confident that quality would increase, and they were confident that costs would go down.

So they weren't afraid to enter into a COPA arrangement. They weren't afraid at all, because they knew -- they -- they had confidence that those two things would happen, despite the fact that many in the community didn't necessarily share that confidence. But the COPA gave everyone the security to go forward.

Well, sure enough, when we merged the two hospitals, we had two pretty good hospitals, and as Dr. Gelertner said earlier, healthcare in the nation was really in a state of crisis relative to hospital care.

We had two pretty good hospitals, but simply stated, quality goes up when we can do more -- when you can do more of it. So you have two hospitals that merge into one, and the staff that you have there is going to do twice as much volume, and volume will deliver quality.

And, in my opinion, and I think that there's lots of studies to show that quality is on the increase at Benefis, and Benefis is on its way to becoming not just a pretty good hospital, but a great hospital, because the merger increased that volume opportunity for expertise to grow and grow.

The second thing was they were confident that in merging the two hospitals, costs would go down. And it wouldn't just be the fact that they would have two departments and they can merge in with less people, and it

would suddenly become one department and, therefore, it would have less staff and, therefore, it would be less costly.

That certainly happened, but the best practices that came from both hospitals resulted in a decrease, an efficiency, a better way to do things, and it resulted in tremendous efficiencies that occurred that where now we are lower cost than most hospitals of our size and situation in the nation. So those two things ended up being tremendous successes.

The COPA helped us stay on track. It was really difficult; it was really challenging. It was hard for the community. It was hard for the staff, the staffs of both hospitals, to come in and merge into a new culture. There was nothing easy about it. It was difficult for the physicians to adjust to delivering care in one hospital instead of two. It was tough.

But after ten years, we really did make tremendous progress, and in both quality and in cost control, it's been successful. And we -- we owe, really, that success to the oversight of the attorney general in -- in the COPA that helped us get there. I mean, because it did provide a track for us to go on to get there.

But as has been stated by others, we're in a

different playing field today, and it's a different situation today. And I join the others in encouraging you to consider sunsetting the COPA and allowing the hospital and the board of directors to continue to oversee the mission of the hospital to best serve our community in -- in the many decades to come. We appreciate your help.

Thank you.

MS. ORR: Thank you.

Is there anyone else here? Yes.

MR. CARLSON: I'm George Carlson, the director of the McLaughlin Research Institute of Great Falls.

The McLaughlin is an independent, nonprofit basic research organization. Now, it might not be immediately apparent, but when you go to the doctor or you go to the hospital, the therapies that you receive are the result of research, basic research, that went on years ago. We're funded at this research institute primarily by competitive research grants by the National Institutes of Health, which don't begin to cover the costs.

Now, I'd like to give you just one example of the importance of basic research in clinical practice. You might not be aware that in the '60s and '70s, right here in Great Falls, Jack Stimpfling and Ernst Eichwald were doing genetic transplantation experiments in mice. Their work in developing assays for histamine

compatibility antigens in these creatures led directly to successful organ transplantations, such as bone marrow and kidney transplantation in humans.

This work was done at departments -- well, first at the Deaconess hospital, then later at the Columbus Hospital, both nonprofit organizations who supported this basic research with their revenue dollars.

So I'm arguing in favor of removing this revenue cap from Benefis Healthcare, which gives them freedom with their excess revenue to do good works. Doing research is not going to generate income for anyone.

You may have been here or may have heard that Mr. Huntsman, who's the founder of the Huntsman Cancer Institute in Salt Lake City, was here Friday. We have an alliance with Benefis Healthcare, and now with the Huntsman's Cancer Institute, and it emphasizes that support for research is a philanthropic endeavor.

Mr. Huntsman doesn't expect any financial return, the Huntsman cancer hospital expects no financial return for their investment in research, and Benefis Healthcare expects no financial return for their investment in both basic and clinical research.

You also may know we formed our alliance with Benefis in 1997, and they were under the COPA revenue cap. And in spite of their restrictive revenue stream, they

help us with what they can with our development costs, again, because these research grants can't cover the real cost of doing basic research.

So this investment and this collaboration with the nonprofit community hospital is important not only for the continuing health and -- and betterment of health now, but for future generations. With research that we're doing now, we expect to have impacts in five years, in ten years in the treatment of patients.

So I'd ask that you really consider releasing Benefis from the restrictions and the administrative burden of COPA, not only for the support of basic research, but also for things that are also not cost generators that they're doing because they're members -- good members of the community and with philanthropic intent, things like Mercy Flight, doing skilled nursing centers, things that are losing money rather than generating revenue.

And it's the ability to have release from the cap that will enable them to reinvest those funds into works that are for the betterment of the community and, through research, for the betterment of human kind.

So thank you.

MS. ORR: Thank you.

MS. PETERSON: Good afternoon. My name is

Cindy Peterson. I'm going to be discussing from the perspective of the emergency department, and also a little personal perspective also.

I've been a member of the Great Falls community and an employee of Benefis Healthcare for more than 20 years. I recently retired from my role as manager of emergency flight and trauma services. I was a member of the leadership team during the merger that created this COPA.

A role of a community hospital is to provide vital healthcare services to meet the needs of the customer and the community. Vital services include the emergency department and Mercy Flight. These services save lives and are critical.

Emergency care must be available 24 hours a day, 7 days a week. The doors are never closed and closed to no one. All are treated regardless of ability to pay. Illness and injury strike indiscriminately, could be old, young, rich, poor. Any one of you could need these critical services. Lives depend on this.

The operation of both Mercy Flight and the emergency department are extremely costly, but necessary and vital to our community. Despite caring for an increasing number of patients in the emergency department each year, ERs do not make money, but rather reimbursement

costs do not pay for the services rendered. These losses must be covered by other revenue-producing services. At our community hospital, the constant financial pressures of offering lifesaving services, such as the emergency department and Mercy Flight, may become too draining.

On a personal perspective, not only am I a member of this community and a past employee of Benefis, but I am an avid healthcare consumer. All of us want the newest technology, services and healthcare specialists available to treat our needs locally. This, again, requires financial backing. We are very fortunate for the care and services that are available here at Benefis.

I have cancer and have been receiving chemotherapy treatments here in Great Falls for the past three years. But my future is filled with more of the same. I want to trust that I can stay here with my family and my friends and receive the state-of-the-art interventions, access to clinical trials, and evaluation treatment by qualified specialists of the highest caliber.

I do not want to take my healthcare dollars out of state, but would rather keep them here to develop the cutting-edge treatments and technologies that allow me and others to live the quality of life that we desire.

If you have cancer like me, or suffer from heart disease or stroke, require surgery, are pregnant and in

need of prenatal care, or you just end up requiring stitches in the local emergency room, it's true for us all: We want and deserve the best.

I cannot emphasize enough the importance of the availability of emergency services for all of us when they are needed. We all expect emergency departments to provide expert medical care when we need it. Emergency departments are a necessary service for every community, caring for the critically ill or the critically injured.

ERs care for people who have to -- have nowhere else to turn and is often the only source of care available at night, on weekends and holidays. These lifesaving services are costly, but essential to our community.

I thank you for listening to my perspective.

MS. ORR: Thank you.

DR. HARPER: Good evening. I'm Dr. Todd Harper. I'm an emergency room physician at Benefis Healthcare. I've been there for the past seven years. I represent a group of emergency physicians totaling seven of us, six of the seven being board certified and residency trained in emergency medicine and one currently sitting for his boards.

We are here in support of Benefis and relief from the COPA, and I'd like to share a little bit of

information that some may not be aware are of, and that's the services that are being provided at Benefis.

We -- over the first four years that I was here, we were pretty stable with about a 23 to 25,000 emergency room visit patient load per year, and over the last 3 years that's gradually increased by about 4 to 5,000 each ear.

What's interesting is that the patient mix has dramatically changed with those increases over the last 3 years. Last year's data shows about a 47 percent increase in the -- in the uninsured population that are seeking help for healthcare at Benefis who are not able to obtain healthcare with other sources.

We also during this time have recognized and been proactive, with the support of Benefis, to try and meet the needs of the community, and have not only expanded the emergency room in terms of number of hours of coverage by a physician to 40 hours a day instead of 36 hours a day, but with Benefis' support, we've also added a 7 room urgent care or fast track to the emergency room to try and create -- or meet the needs of the increasing population that's seeking healthcare through the emergency room.

I'm also the medical director for air medical transport services at Benefis, and I have a real concern

as to the -- our continuability to provide those services under the current guidelines. We're in an ever increasing market of competition between Kalispell and Billings, and even Missoula, extending their range into our region to obtain patients. This has become a very competitive market and not necessarily a financially profitable, more likely a losing proposition for most hospitals.

But our concern is that we are -- this is not going to change, this is going to continue to increase, we believe, and the numbers who are going to seek healthcare through the emergency department, both in emergent status, as well as primary care, for that matter, they just have no other resources to turn to.

We are hoping, as a result, that those guidelines may be lifted, so that with the support of Benefis, we, as the emergency room physicians, can continue to expand those resources for those patients who are most in need of healthcare and are seeking the emergency room for that.

Thank you.

MS. ORR: Thank you.

MR. AMMONDSON: I am not Mayor Gray. He's standing over here.

I'm Curt Ammondson. I was the mayor when they had fist instituted the commission-manager forum in Great

Falls, and that's been quite awhile ago, but it was a good experience, and we have a good system going with Mayor Gray taking care of it now.

We're here today to talk about healthcare, and I just have a few words to say about COPA. I'm not an expert on healthcare. It's my observation that Benefis Healthcare has met the major requirements of COPA. It is no longer necessary or beneficial for those three major requirements to be served, for instance, cost saving.

You've heard several speakers mention the cost savings that Benefis has already received. They need a little leeway so they can have better services.

Benefis has continuously had a policy of no denial of service, and that was one of the requirements, and they will continue to have it.

Benefis has received many national awards which indicate a high quality of care at Benefis.

But competition was one of the factors, too. Competition is alive and well in Montana, as the people at Benefis know and most of the doctors know. Many of our people in Great Falls decided to go out of town to Helena, Kalispell, Missoula, Billings, anyplace, for care, when they could just as well stayed here. So there is stiff competition. We don't need it right in town; we have it in the area. So the competition problem is no -- no -- is

not there.

Additionally, Benefis has available most of the services that other hospitals may not have, such as the air ambulance. How necessary that is and how necessary it is to have money to pay for it, but through the services that people pay for.

I think it's sufficient reason, with the reasons I've given, to believe that Benefis has met the COPA requirements, and it can be forgiven.

MS. ORR: Thank you, Mr. Ammondson.

MR. GRAY: Hi, my name is Randy Gray. I also am a former mayor of this great town. I am a -- I'm a retired, that is reformed, lawyer, and I was mayor of this town for about six years, and I was on the city commission for four years before that.

I served on that commission, with great pleasure, with Bill Downer, who was the CEO of Columbus Hospital. I also was a high school chum of Curt Wilson's, who was the CEO of Benefis. So I won't go back into the original merger of the hospitals, but let me fast forward to the past ten years of the COPA.

I am, by the way, speaking for myself tonight. I represent no one here.

But I was intimately involved, when I was involved with the City of Great Falls as mayor, in the

creation of the Great Falls Development Authority. We regularly referred to this area of Montana, not just Great Falls, but to this trade area, as the Tribune trade area or the Benefis service area. So Benefis is synonymous with -- with this region of Montana. It's one and the same.

The COPA, at the time, was a necessary and useful instrument to make sure that there was an oversight for when the competition the two hospitals were giving each other was eliminated. So the COPA was necessary and appropriate at that time. Then there was concern about the elimination of the competition between these two hospitals, and there -- there needed to be some public comfort factor that someone was kind of keeping an eye on the shop.

But in the past ten years, the market has responded to what initially was -- was viewed as a lack of competition, a vacuum of competition, if you will, and those things have developed on many levels. Locally, competition has developed, of course, with the clinical surgical outpatient center. Competition has developed through the Central Montana hospital and their partnership with Essentia, the clinic specialty center and their partnership with Essentia.

On a statewide basis, sort of intrastate, within

the borders of Montana, competition certainly has developed as other trade areas, Missoula, Kalispell, Helena, Billings, sort of reach into our trade area, and particularly into the outlying areas in this trade area, where patients now are being siphoned off, for example, to Kalispell or other places. So there is competition. People can vote with their feet.

And, clearly, there's regional competition, Seattle, Salt Lake City, Spokane -- my mother-in-law just had some surgery in Spokane out there -- Minnesota. There's -- there's regional competition.

So, in the last ten years, there hasn't been a continual vacuum of competition. The market has responded, and competition has come in.

At this point, as I see it, the issues use are these that the attorney general needs to keep -- keep its eye on:

Number one, access to care. And I guess I would go back to my personal example here during my years as mayor. One of the very innovative partnerships that was created, not generally known in the community, was a partnership with the Indian Family Health Center for the City of Great Falls, who are CDBG Block programed, and with Benefis hospital.

We created an opportunity for the Indian Family

Health Center to buy an ownership, an equity position, in the facility that they had been renting that allowed them to free up some capital so they would provide more programs. So example after example like that have existed over the past ten years in my personal experience where we have had partnerships with -- with Benefis.

A couple of other examples certainly apply, and that is that the -- the emergency room of Benefis, of course, takes all comers. You might say ditto for the air ambulance service, for the ICU, for the neonatal ICU. No one is turned away if they say they don't have insurance. And that's really important for a community to have access to those -- to those facilities.

Number two, an issue needs to be raised on the quality of healthcare, not just access, but quality. And I think Benefis, in the ten years since COPA was adopted, has time and again passed every test on quality.

And, finally, I think the attorney general needs to be looking at affordability. And, once again, over the past ten years, time and again, it's been proven that we're cost competitive, even though we have one -- only one major hospital here.

In summary, I would ask the attorney general -- in summary, I would thank the attorney general for keeping an eye on this -- on this difficult experiment over the

last ten years. But at this point, I would suggest that we have the major healthcare provider in our community that now has one hand tied behind its back. It's time to release that hand. It's time to allow that provider to be quick and nimble, which are two things that, in a very rapidly changing marketplace, any provider of services needs to be quick and nimble.

With the COPA in place, they can't be quick and nimble, and they, therefore, can't provide the quality of service and the cost competitiveness of service that they could otherwise do. In short, it's time to let the COPA go.

Thank you very much.

MS. ORR: Thank you, Mr. Gray.

Why don't we just take a moment before you begin, if I might, and get a show of hands those of you who intend to come up and provide comments in this category of supporting the sunsetting or the dissolution of the COPA. How many more?

And how many -- if I could see a show of hands of those who came to provide oral comments about retaining the COPA?

Okay, I -- I think we're in good shape here time-wise. Why don't we continue, and then we'll figure out if the consensus is that we should take a break.

DR. TIERNEY: Thank you. Good evening.

Good evening, Miss Orr. Thank you for being here tonight.

My name is Dr. Greg Tierney, and I'm an orthopedic surgeon with Great Falls Orthopedic Associates.

I've been practicing in Great Falls for 12 years, and there -- there are some in my practice of 10 physicians to have practiced over 30 years here, and we can all attest to the fact that the face of healthcare delivery in this area has changed dramatically in the last few years.

Whether it's insurance products that scare patients away from their provider of choice, competitive outpatient surgical and ancillary services, or now competitive inpatient services, Benefis Healthcare is constantly under pressure to adapt and remain solvent in this new era of medicine.

We recognize that physician groups, insurance companies and hospitals are businesses that must be run in such a fashion as to keep the doors open, but governmental regulations, standards of care and good patient experiences dictate approaches to the business of healthcare that are unlike any other business model that I'm aware of.

You should be aware that over the last ten-plus

years, our group has explored models of owning our own office complex, complete with outpatient surgical suites, x-ray, et cetera. We had the opportunity to make Central Montana Surgery Center, and subsequently Hospital, very solvent if we brought our cases there. We had the opportunity to be partial or complete owners, but in the end our philosophical belief in the need for a financially strong hospital that could meet all patient needs, regardless of pay or mix or time of day or acuity of illness, prevented us from pursuing that route.

We told Mr. Peter Shick, the manager at Central Montana at the time, that when they opened an emergency room and an ICU, that we would increase our support, and that obviously never happened.

The COPA has done its job. It allowed the merger of two hospitals to occur without monopolistic predator pricing to occur. But the time to sunset it is now. Benefis Healthcare is one of the most valuable community assets that Great Falls has, and it must be able to adapt and face the competitive challenges it faces from both within and outside our community. It's hard enough to navigate through the healthcare mine field as it currently exists without having to do it with your arms unilaterally tied behind your back.

The Benefis Healthcare board of directors is a

well-balanced, dedicated group of volunteers who, I think, stand ready to guide the hospital in the right direction, mindful of their responsibility to the community and the area, like all the other healthcare entities in the state, without added governmental oversight. I respectfully request you sunset the COPA at this time for the protection of our community asset.

Thank you.

MS. ORR: Thank you.

MR. CRUM: Good evening. I'm Dave Crum, assistant director of operations and development at McLaughlin Research Institute for Biomedical Sciences, and I'm am here to speak about the Benefis-McLaughlin alliance and what we have been able to accomplish. I would like to encourage you to eliminate the COPA, so the alliance can grow in the future.

In the past eight years, McLaughlin has worked with Benefis in the alliance to secure federal grants to do education on cancer genetics and genetic ethics. Independent doctors, Great Falls Clinic physicians and McLaughlin scientists conducted these education programs.

The implementation of these programs helped in the development of the Sletten Cancer Institute. The former director of the genetic ethics project is now the genetic counselor at Sletten. In addition, a physician

associate is now training at McLaughlin and is paid by the Sletten Cancer Institute.

The -- the Benefis-McLaughlin alliance grew into the alliance which now includes the Huntsman Cancer Institute. And that is dedicated to providing new treatment options for cancer and expanding research that will improve healthcare for everyone.

A Huntsman-Sletten-McLaughlin alliance provides the opportunity to recruit a physician-scientist to Sletten. This position would split time between seeing patients and doing cancer genetic research at McLaughlin. The alliance gives us the ability to -- to recruit some of the best physicians and further expand cancer research that will improve treatment for those suffering from cancer.

The elimination of the COPA could provide the funding to help expand a Huntsman-McLaughlin-Sletten alliance so it can reach its full potential of improving care for individuals and families suffering from cancer. We would hope, by eliminating the COPA, that Benefis Healthcare would have the necessary resources to grow, helping the alliance to grow and, finally, helping McLaughlin to grow.

Thank you very much.

MS. ORR: Thank you.

MR. CHRISTENSEN: Good evening, and thank you for this opportunity to speak on behalf of the elimination of the COPA. I'm Jim Christensen. I'm the CEO at Pondera Medical Center in the Conrad. I'm also the vice chair of the Northcentral Montana Healthcare Alliance, and I also sit on the Sletten Cancer Center board.

I came here to Pondera Medical Center at the turn of the last millennium. And I can remember as a child hearing that for the first time and thinking, My God, you must be older than dirt.

I come from the Midwest, where there was a population of a little bit more than 1,000,000 people in a 45-mile radius of a small rural hospital. We had 1 university hospital, 4 tertiary care facilities and 11 rural healthcare facilities, all within 45 miles.

It was interesting to note that the four large tertiary facilities actually fought over who was going to assist our small rural hospitals first and foremost, yet none did. It was too much of a competitive arena. We all competed for the same primary care patients that one another so zealously sought.

The small rural hospitals believed themselves to be the ultimate gatekeepers, the large hospitals feeling they were best at routing and servicing all patients, and the university hospital firm in their belief that only

they could address all of their patients' needs all of the time, and naturally, Mayo Clinic, supremely smug in their general omnipotence. Yet none of them came to our assistance. They couldn't afford to. It was a competitive environment.

When I first came to Pondera Medical Center, we banged on the door at Benefis. It was right after the merger. Nobody -- nobody answered the door; nobody answered the phone. If anybody did answer the phone, we were told, "Well, we could help you out for a small, modest token fee."

The concept of tertiary care means that they take everything, all comers, everything that comes their way. The concept of rural healthcare is, just as I said, that gatekeeper. Everything that comes to our doors, we have to deal with it. We can deal with them on a long-term basis, whatever the situation allows.

We have to keep that patient alive long enough and well enough and stable enough to get here. And make no mistake about it, that's where everybody in our region, from all 14 of the MHA hospitals, come. This is the facility of choice. It's also the facility that has not let anyone down in that region.

We banged on that door, and we banged on the door, and finally, with a change in administration,

principally Mr. Goodnow, the door became ajar. The next thing we knew, we had an alliance, a full-fledged voting membership in a region that included Benefis, but all the way up to the Hi-Line, south to White Sulfur Springs, Fort Benton, Choteau, Conrad, Shelby, Cut Bank, Browning, and I believe two reservations. Everything that leaves us by helicopter largely comes here; everything that leaves us by emergency ambulance comes here. All comers.

The door came ajar, and the next thing we know, we were the recipients of -- of a lot of good things, not just the hand-me-downs that a large tertiary care facility can afford to do. Benefis routinely, because of their quality, will write off equipment in five or ten years. In the rural environment, we don't write things off after 25 years.

We've received millions of dollars in services. Most of the facilities in the region now have full teleradiology, a Pax unit that allows almost instantaneous reads and diagnosis abilities. It's a million-dollar -- multi-million-dollar investment on Benefis' part.

We have a Dexa scan unit that travels to our rural areas, assisting in the diagnostic capabilities of a largely -- our largest population, our seniors. All the of us have benefited by those hand-me-downs I spoke of, equipment that's been replaced, but still certainly

serviceable to all of us in rural facilities.

Specialists who refuse to treat our patients, for example, now are urged to either treat those patients or, upon treating them, release that patient back to the primary care arena, so that our physicians, those primary gatekeepers, can get a handle back on what's going on with their patients on a day-to-day basis.

We receive services of strategic planning, grant writing, education, medical diagnostics, telemedicine, staff, staff retention, recruitment. And these all represent giant strides by Benefis in the last four and five years to become that supportive, less competitive tertiary care organization that the COPA detailed originally should be. There's never been a greater rapport, a stronger understanding, and a more mutual respect and honest relationship than is currently enjoyed by the alliance and Benefis.

The day's gone when we no longer have to justify the presence of our acute care cardiac nurses in the advanced cardiac life support class sponsored by Benefis. We used to have to beg to get into that. Now, all of a sudden -- well, not all of a sudden, the last four or five years, Benefis understands that sharper nurses in the rural areas mean better patient care delivered to their cardiac care unit. And that transcends all the care

departments.

Benefis has recruited CRNAs for three of us on the Hi-Line. This means that Benefis has only forsaken some of the surgical cases that they might have otherwise picked up, to be taken care of in our rural care organizations here in real rural America. That's competition.

Lastly, on a personal facility note, recently, when faced with a patient census issue, the MC struggles with the numbers, as -- as all small rural hospitals do, to determine where a specific portion of our patients were migrating to and how we could better service their needs. We were sure that they had gone to Benefis, but we didn't know why, why the sudden change.

Benefis and Mr. Goodnow and his staff have now stepped forward and are helping in a review process to find out where and why and how we can join hands to find out where, if there is indeed a gap in our patient care in the rural service delivery model. That's competition.

There have been huge wholesale changes at Benefis under this administration, a whole culture change, if you will. I suggest we all learn a little about competition from this gentlemen and his staff, his physicians and his board. I suggest this is what competition is meant to embody, and I suggest this new and

improved Benefis is here to stay for all of us and our healthy lives forever.

Thank you.

MS. ORR: Thank you.

MR. GOODNOW: Hi, I'm John Goodnow, and I didn't really know what I'd say tonight. I thought I'd come and listen first. And I'm CEO at Benefis, and it's great to see such a nice, big crowd here that's interested in this vital question about this community asset, and it's great to have you here as our guests and kind of hear what the community has to say. And it's been wonderful for me to hear what's been said tonight, and I'm going to try not to repeat a whole lot.

I do want to say just a couple of additions, though. One, I think the community, the board, the attorney general's office did something real courageous and very, very smart ten years ago when they created the merger. I'm sure there were a lot of people at the time that didn't think that, but that was a wise decision, and it's proven out that way over time.

Even though I wasn't here at that time, I'll tell you something else. A lot of the mergers that happened around that same time weren't successful. Nationally, if you go back and look at data -- there were a bunch of them around then -- many of them failed, at

least failed to achieve the promises, the promises of lower costs, improved quality and greater access to healthcare.

Those were all achieved here in this community, so there's a huge congratulations that needs to go out to the community, to the attorney general's office, to the board, to the whole hospital staff and medical staff that made that happen. It's really wonderful.

The other thing, too, is Benefis has not only met the expectations that were set forth at the time of the merger, it's exceeded all of those. Now, the one question you can ask yourself was, did it exceed those expectations because of COPA? And my speculation to you would be no, it did not.

It exceeded those expectations because of the level of commitment set by the board, the policies that came down, the expectations of that board that were then carried out by the leadership team and by the entire hospital staff and medical staff. So all of these wonderful things that have happened in the last ten years were because of the dedication and the direction locally.

COPA was a good thing ten years ago. I -- and I found it a pleasure to work with the attorney general's staff over the time that I've been here. But I think the key point, and it was made very much more eloquently than

I could ever make it tonight, is, it was a good thing ten years ago, it served its purpose, it's time to -- its time has passed, and circumstances have changed.

The other thing I want to tell you is that the board is certainly committed to access to care, to quality and to cost control going forward. So's the management team, so's everybody in the hospital. That's going to continue. And the other thing that's going to continue is that Benefis is going to be a wonderful asset for our community, for our region and, in some ways, for the entire state.

And I guess the thing I would like to end on is just to say -- too many good things for tonight. I -- I don't get emotional, sorry. What an honor it is to work for Benefis.

MS. ORR: Thank you, Mr. Goodnow.

MS. ORR: Why don't we take a five-minute break?

(Recess taken.)

MS. ORR: Let's get started again. Let me remind everyone that there is a sign-up sheet in the back of the room, and it would be very useful to have your name that indicates your attendance.

Are there any other people who would like to speak in favor of repealing or sunsetting the COPA?

Why don't we go ahead and receive comment from

those who aren't in favor of retaining, amending or modifying the COPA, if there are any.

MR. STEVENS: My name's Paul Stevens. I am with the Cas-Co Greens of the Green Party of the United States.

I've been following this hospital merger and so-called Benefis affair since '96, and then actually back to 1947. I was born in the old Deaconess hospital, as was my father before me, in the even older Deaconess hospital.

The merger -- which this is kind of a tertiary effect of the merger which occurred in 1996. The merger, as you all know, was vastly unpopular in Great Falls. I don't think there were ten responsible people initially who were in favor of it.

And when -- when the merger was first proposed, we looked up the consulting company which put the deal together. I believe the -- the board at that time hired this company to come in and tell us how to modernize, rationalize, make more efficient our medical facilities here. And that company, if you remember, was called Arthur Anderson.

Do you all know who Arthur Anderson was? This is the consulting company which was responsible for Enron. It's no longer in existence. It's gone bankrupt. It also had a large -- it was one of the five large accounting firms in the country, and that part is totally broke.

It's nonexistent.

So, basically, what the people of Great Falls did, through their board, and I believe you heard some of them speaker earlier, we turned our healthcare system over to an Enron model, and that's what we still have. We have -- the Benefis system is our version of Enron healthcare.

I've told people that I knew in here, as I watched the first half of these proceedings, that I was amazed, it was like being at a Communist Party congress. Everyone here is a true believer, everyone is absolutely in favor of what exists, and everyone is afraid of and subservient to the authorities who are mostly represented at this meeting.

After the merger, which, as I say, nearly everyone opposed -- nearly every physician in town opposed it, every patient, every family who had contributed to the endowments of the two hospitals. One was Catholic, one was Protestant, so it pretty much split the community.

But the Deaconess was several times larger, two or three times larger, I guess, and it also had all these efficiencies and economies of scale we've heard about, so its rates were somewhat lower, but the Columbus, being a Catholic Hospital and being run by the Sisters of Providence, had a different ethic.

They weren't after profits; they didn't just look at the bottom line; they cared about people. It was the families of people that worked there, it was the parishioners, it was people in the Catholic community that went there, and they all got very excellent care, regardless of their financial status.

The Deaconess, too, was an ancient organization. My grandfather was a close personal friend of Brother William Wesley Van Orsville (phonetic), Brother Van, who started that, along with a hundred churches and, I believe, six or seven hospitals around the state and a college or two.

So we always loved the Deaconess and got very good care there. We knew the doctors. We were also members of the clinic, so -- which is another group in this current controversy. The Great Falls Clinic goes way back to just after World War II and -- a very highly regarded medical provision group, which is now trying to have its own hospital, since it has not had very good luck with the newly merged Enron model Benefis hospital.

Okay, this is all stuff which you should know. You haven't read it in the paper, lately anyway. You haven't heard it from any people, because everybody, like I say, is at the Communist Party congress, and they're all boosting whatever is happening here.

But the peculiar thing about this particular hearing, I wanted to talk about that now, is that this is a hearing in favor of deregulation. After the merger happened, it created a monopoly. There's basically two models of public services which you can have. You can either have state owned and controlled, you can have a regulated monopoly, or you can have a competitive system, where there are several providers of whatever services there are.

In the case of something like healthcare or education or electricity, you can't really have that kind of competition. Healthcare, you probably could. I mean, we had competition with two hospitals. It was very successful. They were very highly regarded. Both hospitals were graded in the 90th percentile in terms of -- of quality of service and customer satisfaction.

After the merger and the monopoly -- and the only reason the monopoly happened at all was because of this COPA. If there hadn't been this COPA, it would have been entirely illegal. And, in fact, the laws had to be changed anyway in order to have a monopoly of service like this in one town, for one major competitor to take over the other one.

They kind of twisted it around, because, in effect, it was the small hospital which swallowed the

bigger one through Providence Services management. But that, I think, was just kind of a cover or a ploy, and in fact Benefis is now trying to get out from under Providence management.

I don't know what the status of that is, I haven't heard for several months, but if Benefis does in fact divorce itself from Providence oversight, then I think all of the gains in the past six years which were spoken of in terms of quality of service and customer satisfaction, and just the morale of the people that work there that you are a testimony to as well, that will probably go away, because with -- without the regulation and without the -- the religious aspect which Providence provides, medical ethics seems to go out the door and profits take over.

If people don't care, if they're not under a supervised moral and religious environment or other ethical environment, then they -- the bottom line will take over and it'll all be about money, which, it looks to me, pretty much is the case anyway at Benefis now.

So if you are going to get rid of the Sisters of Providence, the Providence Services oversight, then you really need the COPA. You need state regulation to keep your prices down, to keep the quality of services there, to have an ombudsman or some kind of recourse when

patients don't get good service. All those kinds of things will -- will help keep Benefis, as a monopoly, in line.

If you get rid of the COPA, then I would suggest the only thing to do would be to undue the merger, sell the Columbus facilities and other associated things to the clinic and this organization, which also has a cap requirement. We would then regain our Catholic hospital in Great Falls, and then you would be free to compete as a corporate-business-type entity under Benefis.

So, I don't know. I mean, we're doing this in pieces, and we're not connecting the pieces together. There isn't any logical pattern to the overall thing. But I would say, if you're going to get out from under the Providence Services, and if you are not going to allow a competing hospital, which you're in court trying to stop, then you definitely need the regulations. So one or the other should work.

Thank you.

MS. ORR: Thank you, Mr. Stevens.

DR. HINZ: I'm Jeff Hinz. I'm a physician at the Great Falls Clinic. As you can tell, I had time to go home and exercise before I made my comments.

And I'm a little bit out of order as far as our organization. I'm actually here to come speaking for

children, not for Benefis, not even so much for the Great Falls Clinic, but for children.

By the way, Miss Orr, I was offended by your comment when you said, when the proponents were done, if there's anybody here that wants to speak as an opponent. That was a very offensive comment to me, by the way.

I have three things that I'm going to bring up. One is the demise of critical care pediatrics in Great Falls, which I lay squarely at the feet of the administrative staff of the hospital. We had a homegrown, community developed critical care service for kids, and it was squandered. It was literally squandered. We had a pediatric cardiologist, a pulmonologist and an intensivist. That's gone, only because there were control issues and egos involved.

Now, I, in the past, had an administrative role at the clinic. I have not had anything to do with that administrative role for three years. I take care of kids. I served on the hospital board about ten years ago, and actually left once it became clear to me that Mr. Wilson had in mind at that time a monopoly for the hospital, an entire medical system run by the hospital. I could see that there was only one thing our organization needed to do, and that was to gear up, because that was what was happening.

Now back to critical care services. So by about a year ago, I could see this thing was falling apart. So I leave my practice long enough to meet with the people that are involved, try to bring people back, talked two of the physicians who were refusing to participate, one who was going to leave the community, talked them into staying again. But because of the lack of emotional support, not financial -- this thing -- this thing was homegrown. It basically paid for itself. But because it wasn't under the control of the hospital, it was allowed to die.

Dr. McAllister left the community, Dr. Eichner married and went to Helena, and Dr. Ruggerie, and at his tender age should not have to do call every other -- every night again, like he did in the first part of his career.

So this community no longer has critical care services for kids. I'm glad my grandchildren aren't in this community. That's a sad thing to say. And it was purely control; it -- it wasn't money.

Dr. McAllister, I tried to get three hospital board people and Mr. Goodnow to have an exit interview with him. Do you think anybody wanted to hear the bad news? No way. It was not done.

Second issue: Serious COBRA violation. I'm on call at night; a little boy comes in with what looks like a torsion of the testicle. You've got a couple of hours

to do something about that, and the testicle dies.

I call the urologist on call. That individual says, "I can't do it." So I get on the phone, I start calling the other people who I think might come in, some of the general surgeons. Okay, finally, I can't find anybody, so I call a urologist in Helena -- or Billings, who takes the baby in the middle of the night. Now, this is hours later, okay, and this kid gets Life Flighted down.

A serious COBRA violation occurred when that physician didn't come into the hospital. Okay. So I reported it to the chief of surgery at the time, I reported it to the head of the medical staff, I reported it to Dr. Dolan, who is, whatever, medical director of the hospital, and assumed that this thing it going to be handled correctly.

This thing -- this thing was an open and shut checkbook case for the hospital if the parents had been litigious, okay?

The physician, I don't know if anybody ever spoke to that individual, and as far as I know, she still takes call for children. That's not right. That's called institutional blindness, and it drives me nuts.

Years ago, when I was on the hospital board at Deaconess then, I was in favor of the merger, because

there was so much institutional blindness going on in one hospital, that as a physician taking care of kids, where there's no money, this isn't glamour, it just drove me nuts to see the lousy care sometimes provided, and I wanted to see more responsibility.

I think that Benefis has its institutional blindness going on right now, and I don't expect it to get better. The physician involved was someone who, I think, was some way supported by Benefis. And I don't know that, and I quite frankly don't care.

The third point I have to make tonight is the largest problem in this community is what? Heart care, cancer care? Hell, no. It's mental healthcare for children. Do you see that on the radar screen for this wonderful community hospital? I don't think so.

I've personally gone to Jim Cummings, Mary Moe, Jim Peterson and have talked to them about these issues. Children's mental healthcare should be at the top of the list. That's who's going to be working for you and paying for your retirement, and they are going without services.

I don't know that this is a statement for or against the removal of the COPA, but certainly I want to keep some kind of handle on a hospital that I think is beginning to operate very -- I -- I could pick better words.

I'm concerned about whether they are really looking at their responsibilities for this community, and certainly for children, which is now, quite frankly, the only thing I care about.

Anyway, I'm going to go back and exercise. Good night.

MS. ORR: Thank you.

DR. MAYNARD: Good evening. I'm Dr. Nancy Maynard, a pediatrician at the Great Falls Clinic -- I'm Dr. Nancy Maynard, pediatrician at the Great Falls Clinic for the last 22 years. I currently serve as the chairman of our governing board for the Great Falls Clinic, and I'm here to support maintaining the COPA and regulation for Benefis.

Benefis has demonstrated behavior in the past that is antagonistic to physicians and that has contributed to the departure of some doctors from Great Falls. With a hospital work environment that is poor, it is easier for a doctor to move to another community.

Lack of support for an existing program has contributed to physicians leaving, as Dr. Hinz mentioned. The lack of support includes things like trained staff, appropriate equipment, facilities, and support of a program to the public. The more financially marginal the program is, the less support the program receives:

Chemical dependency, psychiatry, pediatrics, pediatric intensive care.

Benefis promotes divisive behavior among the medical staff that creates an antagonistic work environment. There has been a failure at the administrative level to promote teamwork among the staff and physicians, and a failure to focus on patient care. This has led to inefficient initiation of policies.

Another example of divisive behavior by Benefis is actively soliciting letters by Benefis-associated physicians, addressed to non-associated physicians, to be used publicly.

Other subtle antagonistic behavior contributes to a less than ideal work environment that has led to outstanding doctors choosing to leave the community. An example of that behavior is giving less than desirable surgical times to non-associated medical staff, inefficiencies within the operating room.

The most current casualty is Dr. Rick Jensen, an ears, nose and throat physician, who's chosen to leave, in large part because of the negative working environment in Benefis. The result contributes to a nearly total loss of ENS services in Great Falls.

Comments have Ben made by Benefis administration that services may be discontinued, including ones that are

only available at their facility. Specifically at a pediatric department, just recently Benefis administrators listed one of their options was to provide no general pediatric services at their hospital. Is that a true threat of loss of services or just another threat that erodes the work environment into hostility, or does it matter?

With the loss of regulation, the divisive, antagonistic behavior of Benefis will get worse. More physicians will choose to leave, and more services will be lost in Great Falls. The doctors will seek a work environment in other communities where value is placed on providing the best patient care possible. I am in support of continuing regulation.

Thank you.

MS. ORR: Thank you.

DR. KHALIQI: Hello, I'm Tim Khaliqi. I'm a pain management physician here in Great Falls, and I want to speak toward keeping the COPA as a regulatory necessity to help monitor some of the actions of Benefis.

I joined the Great Falls Clinic four years ago, when I was recruited to set up an interventional pain management program for Great Falls and the region. The physician who had been providing some of these services had recently died, and it left Great Falls with no

physician trained in true interventional pain management.

When I first came to town, I originally applied for privileges at Benefis hospital restricted only to pain management. My request for those limited privileges were denied on the grounds that I would not be taking general anesthesia call. I am trained as an anesthesiologist and a pain management physician.

This denial was based on a fact that I would not take call for anesthesia, despite the fact that I did not at that time, nor at this time do I practice primarily anesthesia. I did not practice any anesthesia at the hospital. Furthermore, I was not familiar with the ORs or the surgeons, yet it was expected that I come in in the middle of the night and take call, regardless of the fact that all I was requesting was limited pain management privileges.

Despite several attempts by my partners, including requesting credentialing through another department, attempts at bylaw changes, and even the thought of developing a new department of pain management, to date, myself and now my new partner, Kevin Kelly, are still not allowed to practice at Benefis. This is despite the fact that there are physicians in town who repeatedly ask us for our services when handling difficult pain management cases.

There are patients who may need procedures that only my partner and I can provide. There are patients who, in the hospital, have requested that one of us come over and see them, and we're not able to do that. And, furthermore, we have our own patients who we cannot hospitalize at Benefis because we've been denied access.

There are many other examples of patient care suffering because of the stranglehold that Benefis Healthcare policy has on healthcare services which are provided in Great Falls, and I will detail that in a separate letter to the attorney general.

I would like to relate the story of one patient that happened early on when I was here in town. This patient had severe hand pain caused by a condition that ultimately took her life. She would occasionally need a specialized block that would help restore blood flow to the hand, and I had been providing that on an outpatient basis.

Unfortunately, she had a crisis on a weekend and had to be admitted through the emergency room. There was no one available at Benefis that could provide the block. I was not able to provide the block, even though I was available, because I did not -- I was denied privileges. She had to wait in pain, with a blue hand, limited blood flow to that hand, until Monday, when I could see her and

do the block in a safe area.

My experience has led me to several conclusions. The first one is, the leadership of Benefis Healthcare has demonstrated a propensity to unfairly protect and actively promote groups or individuals that may "side" with them, while actively excluding those that may side against them. The administration of Benefis Healthcare is more concerned about politics than they are about patient care.

Number three, I believe that in the long term, loss of some sort of regulatory oversight would result in patients not having access to specialists in the community solely because they don't meet the good graces of Benefis Healthcare.

And fourthly, as you've already heard, it's happening right now, it's going to be more and more difficult to recruit new physicians to fill the positions that are empty here in our town because of the environment in which they have to practice.

Clearly, Benefis Healthcare has not met all the requirements that the COPA set forward. They continue to deny access to healthcare to some patients. Unfortunately, those patients don't have a real big voice. They may be kids; they may be patients in pain that nobody else really trusts in. But the -- the leadership at Benefis has demonstrated they don't care about those

patients.

I would respectfully submit that is not access to healthcare. They are denying patients the ability to choose by denying certain physicians or certain -- certain procedures or certain lines of service and not supporting them. Clearly, the COPA is necessary as the continuing regulatory oversight that it was designed to be.

The people of northcentral Montana deserve quality healthcare. They deserve to have the right to choose and to consult and develop a medical plan of action with a physician of their choice. They should not have to worry about not having access to that physician or having their doctor leave the community because of the monopolistic business practices and politics of Benefis Healthcare.

Thank you.

MS. ORR: Thank you.

DR. WARR: My name is Tom Warr. I'm a --

AUDIENCE MEMBER: Louder.

DR. WARR: Hello, I'm Thomas Warr, M.D., medical oncologist in Great Falls, and I'm representing myself and my patients. And I'm going to enumerate my clinical teaching and administrative experience here in Great Falls, Montana initially here.

I'm certified in and have been practicing

internal medicine, hematology and medical oncology since 1989. I'm certified in hospice and palliative medicine and have been the medical director of Peace Hospice of Montana since its inception in 1991.

I've been medical director of the American Red Cross Blood Services Montana region for over 14 years, and that included the western two-thirds of the state. I've been medical director of Medallion Home Healthcare for over ten years. I've been director of the Regional Education Conference Tumor Board, a function of the Benefis cancer program, for over ten years.

I prefer quality patient care to business, politics and competition between medical institutions. I'm also a bit of a -- a rable-rouser, and I was one of a very small percentage of physicians who were in favor of the merger ten years ago.

I did -- I do remember a -- a petition that was signed by every physician that I know of, just about, including up to Cut Bank and Shelby, in -- in oppose to the merger. The merger went through, and I -- I certainly had the impression that the hospital board was going to do it come hell or high water.

And I've come to believe that that's my only -- the only explanation for the hospital board's current opinion of physicians' opinions regarding healthcare in

this community; that is, we don't know what we're talking about.

And I would go on to say that I've lived through the merger of the two hospitals. This created -- a fear that created a single large hospital into a monopolistic power to the detriment of the healthcare system led to the implementation of the COPA to protect the small players from monopolistic behavior.

And when I talk about small players, and you're talking about the biggest hospital in the state, the only hospital in the region, everyone else, physicians, patients, the community, even the media, are small players.

Despite the COPA, Benefis Healthcare has become a monopoly and, in my opinion, is misusing that power. For instance, Benefis has the only inpatient oncology unit in northcentral Montana. I've been involved with making it a model of patient care excellence since my arrival here in 1989.

Dr. Jeffrey Stephenson is a radiation oncologist at clinic cancer care located at the Great Falls Clinic specialty building. Two years ago he applied for privileges at Benefis, only to have his application vetoed by Benefis administration. They refused to allow it to be forwarded to the credentials committee. This was a

decision apparently made on the basis of politics and business, rather than for the betterment of patient care, as we noted.

As a result of this decision, Dr. Stephenson cannot see his patients at Benefis Healthcare. Similar to the situation with Dr. Khaliqi, if Dr. Stephenson patients -- Stephenson's patient developed complications from radiation and required admission, Benefis administration will not allow Dr. Stephenson to provide care.

Please note that I'm not talking about privileges for using linear accelerators previously at Benefis West and now at Sletten Cancer Institute. Rather, I'm talking about inpatient services at Benefis East hospital.

You're probably not aware that Benefis was without permanent a radiation oncologist for several months in 2005. Instead, we had a series of locum tenens physicians. One patient of mine had four different radiation oncologists during her five-week course of radiation. Furthermore, neither the credentials committee nor I had any information about the background or training of these rotating transients.

All that while, Dr. Stephenson's application was being held in monopolistic limbo. It would have been of

great help to patient care to have a single on-staff, board-certified specialist in radiation oncologist -- oncology available to see my patients during those months.

And be aware that I did express my grave concerns about this specific patient-care issue to Benefis administration at the time, including Dr. Grant Harrer, CEO of Sletten Cancer Institute; Dr. Paul Dolan, chief medical officer; Julie Hickethier, senior VP and chief clinical officer; and John Goodnow himself, CEO of Benefis Healthcare.

In this example, Benefis preferred politics, competition and business to quality patient care. The only explanation for Benefis' decision that I can think of was that it would promote referrals to Sletten Cancer Institute.

All this, and apparently much more, has occurred with the COPA in place. Relief from the COPA could only make the situation worse in my opinion. I feel that the COPA should be amended to eliminate the ability of Benefis administration to exclude qualified physicians or groups on the basis of competition or politics. It's, in my opinion, wrong that qualified physicians are not allowed to practice at a publicly owned, nonprofit hospital.

Choice is better than no choice, and patients deserve that right. The -- there is value to more than

one point of view. There is no evidence that centralized planning in healthcare is any better than centralized planning in any other industry. I think it's foolish to think so. It's foolish to think that Benefis has a monopoly on good ideas. The COPA protects the community from the Benefis monopoly and should be left in place and amended as I mentioned.

Finally, I would remind all here that the competition we should be facing is not against each other. Rather, our common enemy is suffering and disease. We need to work together. Benefis is simply the best and has all sorts of other accolades that we can see on billboards, but it could be so much better if it had the cooperation of all the physicians in this community, including the largest multi-specialty physician group in the state. We need to work together, because together we can do a better job, and at the same time restore and maintain the trust of our patients and the community in our healthcare system.

Thank you.

MS. ORR: Thank you, Dr. Warr.

DR. AKRE: Good evening, Miss Orr.

MS. ORR: Good evening.

DR. AKRE: The Great Falls Clinic is going to provide additional written testimony to what we're giving

you tonight.

My name is Steve Akre. I'm the chief medical officer of the clinic.

My several partners who have testified have brought up various aspects of monopolistic organizational behavior that has harmed many individuals and driven doctors out of town, resulting in reduced services in Great Falls. Now Benefis is petitioning your office to remove regulation, while at the same time suing us to prevent competition. Help me with that concept.

The COPA issue isn't about the clinic, it's about our community's need for protection against this monopolistic behavior. In January of 2004, Brice Addison, one of my partners, witnessed the announcement that the hospital had given Dr. Harrer $190,000 to leave the clinic. This winter they offered Jim Whittle $2 million to leave the clinic. They were going to pay him that over three years. He declined, by the way. They've approached Dr. Brian Molloy, Dennis Ruggerie and Tom Warr, asking what would it take to get them to leave the clinic.

Our patients have been called at home and urged to leave their clinic doctor and go to a doctor at the Sletten Cancer Institute. Physicians that we have recruited have been called at their home, urged to join Benefis, in spite of the fact that they'd never even met

them.

Benefis has told many of its own employees that they and their families should switch to different doctors, and now the hospital has altered their insurance benefits to force them to change doctors if they're receiving care for cancer. In the last couple of days, their employed physicians are soliciting their employees to switch doctors and come to them for care. I believe they're privacy's been severely violated.

Patient-satisfaction scores are at all-time lows, and the documentation of that I'll be handing you when I get done with my comments.

We do not believe that the Benefis board can possibly be approving actions like this. These behaviors are occurring despite the current level of oversight from your office, they're occurring despite a well-intentioned governing board of directors, and also despite a group of very dedicated and talented employees.

Several people in the community are not testifying tonight for fear of retaliation. They're too intimidated to know that Benefis will receive copies of all the written and verbal testimony. If your office were willing to talk to some people in private and guarantee that their comments would not be passed to the hospital, you would have many more people standing here or -- or

would meet with you in private.

We understand that it is not your office's job to make the hospital behavior better, but eliminating the COPA will permit actions like these to only escalate. And given what has already happened, who can doubt that this will get much, much worse.

It will lead to further loss of doctors both from the clinic and from the independent community. It's going to severely increase the difficulty that we have in recruiting. We are going to lose services as the physicians that prefer -- perform those services accept jobs elsewhere, and the result will be substantial community harm.

This community currently depends on your office for protection against this, and we would respectfully suggest more stringent oversight of their monopoly rather than elimination of the only form of accountability that currently exists in this community.

Thank you.

MS. ORR: Thank you, Dr. Akre.

DR. GALVAS: My name a Patrick Galvas. I'm a physical medicine and rehabilitation physician. I am independent. I am not affiliated with or a member of the Great Falls Clinic. I am a member of MONARC, and that is -- so I have an affiliation with Benefis.

Oi vay! That pretty much sums it up.

There are a group of physicians who have tried to not take sides. It's been very difficult. We see both sides of the story, and we constantly agonize and we discuss. We are faced with a situation that is very, very uncomfortable.

I guess that based upon the current climate -- that is, I have been called by the hospital not trustworthy, they don't trust the physicians, and I am greedy -- it's an uncomfortable situation. It's the place where you work, and you have to be there, and you depend upon them. There is something, in a way, seedy about a physician that doesn't have hospital privileges, as Dr. Khaliqi can attest to.

Yet we see the points. We know the expenses; we know cost shifting; we know what goes on and how they struggle. Now we are looking at our colleagues. We see their points.

I guess what I am asking is if the COPA is lifted, that there is some prudence. I fear that with the current climate, that there are going to be repercussions against those of us who tried to maintain neutrality and still wish to agree to disagree.

Thank you very much.

MS. ORR: Thank you.

MR. CHRISTIAENS: Hi, I'm Allyn Christiaens. I'm the owner of Central Montana Laboratory. We are a private, independent, totally unaffiliated laboratory in Great Falls, Montana. Contrary to several articles in the paper, we have no affiliation with either Benefis Healthcare or with Great Falls Clinic.

Our business was opened up in the Central Montana Surgical Hospital building approximately two years ago. At that time, it was an opportunity for me to live a lifelong dream of opening a business of my own to provide service for patients, anybody that wanted to, to be able to come in and experience a situation dissimilar from what was currently existing in Great Falls; that is, extreme patient-focused care, rapid turnaround, cost affordable testing, and a commitment to customer service that I don't think can be paralleled in this community.

Since we are located in the Central Montana Surgical Hospital building, however, the assumption has been made that having similar names, we must be affiliated. I would like to point out that that is not the case.

I'm here not so much to speak against removal of the COPA, but more to postpone. What has been skirted around in this room for going on two hours now has been basically one issue: Benefis versus the Great Falls

Clinic.

No one's coming to the point of saying, "Maybe it's time to sit down and talk about this thing in a reasonable fashion." We're dealing, on both sides, with issues of power, control, the -- the possible legacy left behind by individuals in this room, and I think we need to rise above that fray.

I'm passionate about providing service and doing the work that we do, but when it comes down to providing care for patients, both entities have frankly made it difficult for us to operate.

The Great Falls Clinic, through their affiliation with Blue Cross Blue Shield and the Montana Care insurance plan, does not allow their patients to see our facility. Or at least they can see it, but their insurance is not going to pay for it. Benefis recently did the same thing.

Now, I don't object to fair market competition. You know, if that's what you want to do, you both have laboratories, you both have x-ray. That's wonderful. I am a free market capitalist. I detest government regulation.

COPA is government regulation, but right now, this is an issue between the Great Falls Clinic and Benefis at the Supreme Court of Montana, and deciding on

this COPA at this point in time is inappropriate. We need to back off.

In fact, I would suggest Attorney General McGrath say, "We're going to let this thing sit on the back burner until we get some litigation resolved." And I would advocate to the people in this room to back off from the rhetoric.

I've never seen the atmosphere in my 30 years of healthcare in Great Falls. I was Benefis employed for 20 years. I know three-quarters of the people in this room. And I've never seen the vitriol that has been expressed in this community to this extent.

The time has come to take the parties and principals involved, and I'd like to lock them in a room, tell them to work it out until they can come to some resolution.

Physicians have an undying need to take care of their patients. Benefis says they need more money. Okay, when this is resolved, discuss relieving the COPA and have an opportunity for them to increase their prices. Increasing their prices is great for me. I offer less. The competition's not a bad thing.

We talk about enemies in this room, and there are no enemies here. They're our worthy adversaries; they're our friendly competitors. Let's knock off the

rhetoric, and let's get down to the dealing with the issues in this medical community in a logical and respectful fashion.

Thank you.

MS. ORR: Thank you.

Have all the people who wanted to provide testimony regarding maintenance of the COPA come forward? Looks like that is the case.

We'll leave the last half an hour for follow-up comments by any individuals who would like to speak, so let me open it up to that.

MR. UGRIN: I think there may be a couple. Could we have about three minutes to --

MS. ORR: Sure, let's --

MR. UGRIN: -- get organized?

MS. ORR: We'll -- we'll take a short break, five minutes.

MR. UGRIN: Thank you.

(Recess taken.)

MS. ORR: Let me ask, how many people wanted to provide follow-up comment? I see two hands. Why don't we get started with that. And I think it looks like we might be able to close at the appointed time, but if we have to go over a little bit, we will.

So, come forward if you'd like.

DR. DOLAN: My name is Dr. Paul Dolan. I'm the chief medical officer at Benefis.

And I guess I have a little bit of a unique history in all of this in that I was the chief of staff at the Deaconess at the time of the merger, was a representative of the Deaconess as they studied the merger, and then shortly after the merger went onto the hospital board, and was a member of the Great Falls Clinic until I took my current position. So I'm kind of meshed in here in a few ways.

I just wanted to clarify a couple of things relative to some of the points that were made earlier. And this isn't to engage in any sort of debate, but I wanted to clarify a couple of issues.

Benefis clearly recognizes that we have an issue relative to pediatric critical care services. And, in fact, last fall Julie Hickethier and I thought we were working hand in hand with the Great Falls Clinic on that issue. We had several good meetings about that, and then entered into a period of, I guess I'd say noncommunication, which was curious to us. It turned out that that period of noncommunication was when they were busy with another venture that they were planning and -- and announced somewhat later.

It is true that we -- when we met with the

pediatricians, we did ask them about the interest in continuing pediatric services at Benefis. That was in large -- largely a response to the fact that one of the announcements in the formation of the Central Montana Hospital was that they announced that they were going to do pediatric services there.

We were cognizant of the fact that all but one of the pediatricians in the community were members of the Great Falls Clinic. And, frankly, our world had changed, and we weren't sure if the pediatricians were going to be working for the good of pediatric care at Benefis or if they had other alternatives or other options.

And that gets into an area that I don't think has really been addressed. And I don't think that this whole COPA thing should be a Great Falls Clinic versus Benefis thing, but the world has changed in terms of our medical staff, in terms of a significant number of our medical staff now has an additional conflict of interest. And it does make it hard, from our perspective, to know whether or not, as we sit down with them, if they're working with us or if there's some other ulterior motive.

The other thing I'd point out is relative to what Dr. Hinz spoke to. He mentioned a COBRA violation. We can't make public pronouncement as we deal with physicians. And the fact that he didn't find out about

what was done about it is the way it's supposed to work. That's just the way the system works.

I'd also point out that at one point in time the community did have a fully trained pediatric urologist. That physician relocated to Billings. Benefis had nothing to do with that. He wanted to stay in the community, and he was prevented from doing so by another institution.

Everyone recognizes the crisis in mental healthcare for children. It's a statewide problem; it's a national problem. I -- I think if we -- if we had the capacity to solve that by sitting down and throwing a little bit of money at it, that would be great, but so far we have not heard of any reasonable solution.

There's this question being brought up of Benefis creating a hostile work environment. It is uncomfortable these days when there's physicians that aren't quite sure what the motives of other physicians are, or when the staff isn't quite sure of what the motives of the physicians are. It's uncomfortable. We're not purposefully creating a hostile work environment.

A lot of the wonderful programs at Benefis have been built by physicians within the Great Falls Clinic. As Dr. Warr alluded to, he was a champion of the hospice. That was really his program, as he built that. And there's other examples of other clinic physicians doing

that. To think that we're somehow trying to create an environment that would drive physicians out of the community to the detriment of our community is ludicrous.

In terms of what Dr. Khaliqi mentioned in terms of not having privileges, that's true. My predecessor, Dr. Paul Melvin, worked for months to see if he could get Dr. Khaliqi privileges. That really was not a Benefis administration thing. That was more of a medical staff issue. The structure of the medical staff was such that the anesthesia department did have control, because technically he was an anesthesiologist and indeed was providing some anesthesia services at -- at the clinic surgery center.

When I started my position, I had the opportunity to meet with Dr. Khaliqi and asked him if he wanted us to take another run at it. At that time he wasn't sure that he wanted to, but we've always kept that door open.

In terms of preventing Dr. Stephenson from having privileges, the exclusive agreement for radiation oncology dates back as long as we've had radiation oncology in the community and dates back to the Columbus days. There has always been an exclusive agreement for radiation oncology, and it's nothing new. Unfortunately, that's just the reality of the situation, and we found it

to be a necessity relative to recruiting a radiation oncologist.

MS. ORR: Okay, thank you.

MS. GOLDHAHN: Good evening. My name is Laura Goldhahn. I'm the chief operating officer at Benefis Healthcare. And I'd just like to expand a little bit on what Paul offered by way of perspective.

It seems to me that generalizations and anecdotal stories do little to represent factually our reality today. And we've heard a number of generalizations and anecdotal stories tonight, and we certainly have our share of those. We won't bore you with those this evening.

But what I would like to put forth is that administratively and with the support of the board, we have undertaken a number of efforts to try to work collaboratively with all of our medical staff, Great Falls Clinic and independent physicians alike.

We've initiated meetings, we've brought in consultants, we've done a number of those things. So, again, to suggest that we are promulgating a hostile environment on purpose just simply doesn't represent what is reality and what has been our effort.

The idea that the environment as it exists today is driving physicians out of Great Falls and causing us

not to be able to recruit, again, when you look at the facts, between the Great Falls Clinic and the independent community, we've successfully brought more than 20 physicians to our community in the last year. And while it's true some choose to leave our community, that's no different than any other medical community where doctors look at different opportunities. I just really believe that the environment we have today, while it is strained and difficult, still has enough opportunity in it that we can attract and retain good physicians.

In terms of approaching clinic physicians to leave the clinic, until recently that absolutely was not the case. And, in fact, we were approached by a number of physicians. Our objective is to keep medical providers in the community, because that provides access. And so when we're approached by any physician or any group to assist in retaining people, we will certainly do that, because that ensures our mission of access to care.

MS. ORR: Thank you.

DR. AKRE: Tom, do I have your permission to say what happened to you yesterday?

DR. WARR: No, I'll do it.

DR. AKRE: Tom Warr created hospice.

DR. WARR: I just want to give another anecdote here. I was going to keep this secret, but the person

sitting next to me over there already knows about it, so shit.

I got a letter, thank you very much, from Julie Hickethier yesterday that says, "This is written notice of termination of the medical director contract for hospice that Benefis has had with you," blah-blah-blah. My contract basically says they have a 90 day "See you later" clause.

When negotiations -- ten-year negotiations with the medical -- the oncology community, including the clinic, independent physicians, and Columbus, Deaconess, then Benefis, broke down regarding a single cancer center in this community, I was approached by Benefis leadership, threatened with my position as medical director of hospice that, you know, it's either join us or your job is gone. And I said, "Well, listen, I'll -- I don't think that that's going to be very good for your PR," and I think they thought better of it, too.

Issues have continued to evolve over these last couple of years since that happened, and I'm without a job at hospice. I just -- I just -- you know, I -- I think that I've done a good job -- if anything I've done a good job at hospice is that it's a very independent, strong program in this community. I feel strongly about its life here, and it will go on without me.

The reason it's been strong is because it does what it has to do despite administration oversight, and we've always had that privilege. We got -- we got ourselves on the radar map there for a while when our inpatient hospice unit opened up, and then it sort of faded out and we started to do our own thing again. And I just -- I just want to say thank you for -- for your support of our hospice program over the years.

And, you know, just -- just one other comment. I mean, whoever it was, Allyn Christiaens, I think, said that he's never seen, you know, the relationship between physicians and the hospital reach the point that it has. And, boy, that's absolutely true.

And it not only applies to the hospital administrators and -- and physicians in this community. All of us -- all of us would like to think -- and let's -- let's talk about hospital board members, too. I get the opportunity to talk to you right now, and I'm going to do that.

All of us seem to think that we know what's best for our patients or, you know, maybe on a micro scale, one doctor or one patient at a time, on a macro scale, you know, regions at a time and stuff like that. We all think we know, and, in fact -- in fact, we all do know. And some of us are not being listened to, or at least that's

our impression.

And, you know, a lot of this stuff is business decisions, you know, that good health -- good healthcare is good business. And, you know, we wouldn't have a cancer center at the Great Falls Clinic if we didn't, you know, accept that after ten years of trying to negotiate with the hospital -- it wasn't our intention to do that, it never was, until it became apparent that we're not going to be able to have a say in radiation oncology equipment in this community until we do it ourselves. And that's -- that's the reason it's happening.

That's the reason it's happening that we're building our own hospital, because we have a hospital administration, we feel, that's not responsive to our needs.

And it was certainly the thing that brought about the Great Falls Clinic Surgery Center. We were not being listened to by the then hospital administration regarding running their outpatient surgery center. We wanted to do it better, we did it; we wanted to do it cheaper, we did it.

You know, so let's -- let's cooperate, you know. And, I mean, I think that, you know, if we cooperated on getting rid of the COPA, you know, hey, get rid of the COPA. There's -- there's one for you. You know, how

about let's start cooperating and -- for the betterment of patient care, and we'll go from simply the best to really the best in this community.

Thank you very much.

MS. ORR: Is there anyone else who would like to provide follow-up comment? Here's one.

DR. PETERSON: My name is Mark Peterson. I'm an anesthesiologist, and I -- I work primarily in the Benefis system and have done so for 24 years, I believe. I've been here a long time. I know a lot of people as friends and as acquaintances.

And what I've seen develop over the years has been quite discouraging, especially in the last five, six, seven years, and I have basically hung on here just trying to stay and do my -- do my job.

And what -- what I would like to see would be for all patients to have access to all physicians in this community. And I think that if we did that, we could keep physicians here. And, you know, our experience as anesthesiologists in this town is that we can't if you don't have access to all the patients. We cannot keep them here. And -- and if patients don't have access to all physicians. And I think it would be good for the community if -- if we went that way. There's a lot of work that needs to be done to do that.

And the other -- the other point that I would make is I think, as physicians, I think -- and administrators, I think we all need to step up and do what we can to make it work here. Because if we can't make it work here, you know, these patients are going to find someplace else where, you know, medical -- medical care is delivered in a less controversial sort of manner.

Thanks very much.

MS. ORR: Thank you.

Thank you all for coming. I think I'll conclude the hearing. Provide written comment to the attorney general if you so choose.

Thank you again.

(Hearing adjourned.)

CERTIFICATE OF REPORTER

I certify that the foregoing is a correct transcript from the record of proceedings in the above-entitled matter.

LISA LEWIS DEVINE, RMR DATE